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## **NASOTRACHEAL INTUBATION**

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### **FIELD ASSESSMENT/TREATMENT INDICATORS**

Possible cervical spine injury with clenched jaw and gag reflex  
Trapped and inaccessible for direct laryngoscopy  
Severe respiratory distress per Protocol Reference #5001 Shortness of Breath  
Patient not able to accommodate 7.0, 7.5 or 8.0 Endotracheal Tube

### **RELATIVE CONTRAINDICATIONS**

#### **Base Hospital Contact Required**

Significant facial trauma, trauma to the face or nose and/or possible basilar skull fracture  
Anticoagulant therapy

### **PROCEDURE**

1. Support ventilations with appropriate basic airway adjuncts, and explain the procedure to a conscious patient.
2. Immediately prior to intubation, consider prophylactic Lidocaine 1.5mg/kg IVP for suspected head/brain injury.
3. Select the nostril to be used and inspect for patency and air flow, select appropriate cuffed tube and pre-oxygenate patient with 100% oxygen prior to attempting procedure.
  - a. If patient becomes apneic, discontinue procedure and attempt oral intubation.
  - b. Lubricate distal tip with a water soluble jelly or viscous Lidocaine
  - c. Position the patient as tolerated. Hold in-line cervical stabilization if neck injury is suspected.
  - d. Administer one (1) metered dose, 0.5mg of phenylephrine HCL to selected nostril May be repeated once prior to additional attempt.
  - e. With one hand, advance ET tube into selected nostril, with bevel out, while applying cricoid pressure with the other hand. Monitor breath sounds continuously while gently guiding the tube into the trachea.
  - f. Inflate balloon with air and ventilate with 100% oxygen then secure tube.
  - g. Verify and document tube placement.
  - h. Monitor end-tidal CO<sub>2</sub> and/or pulse Oximetry during procedure
  - i. Suction the trachea when necessary
4. Contact Base Hospital if unable to place NT after a maximum of three (3) NT intubation attempts or if unable to adequately ventilate patient via BVM.

### **DOCUMENTATION**

Upon arrival at the receiving hospital, the Advanced Skills Evaluation Form on the back of the yellow copy of the OIA Form or electronic equivalent must be filled out and signed by receiving physician. This form must then be forwarded to ICEMA within one week by either the PLN at the receiving facility if it is a Base Hospital or by the EMT-P's Agency EMS/QI Coordinator.

In the event the receiving physician discovers the ET is not placed in the trachea, an Incident Report must be filed and forwarded to ICEMA within one week by the EMS/QI Coordinator/PLN.